Redesign of LTC Programs

Jill Bryant

Department of Health and Human Services

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The South Carolina Department of Health and Human Services (DHHS) is responsible for issuing, delivering and monitoring Medicaid to the citizens of South Carolina. Medicaid is health insurance for low income individuals and/or families. Imagine a parent leaving the doctor's office after learning their child is sick and needs surgery. That parent has no health insurance and has been referred to the Medicaid office for assistance in order to get their child the treatment he/she needs. The parent calls the local Medicaid office and learns that it could be up to a year or more before a decision can be made on their case. Unfortunately, this was the state of affairs for SC Medicaid about four years ago. This was totally unacceptable and the agency set about the create change.

Our Medicaid programs are divided into three primary groupings: MAGI, which represents the children and family programs; NON-MAGI, which represents the aged adults and adults with disabilities programs; and LTC, which represents the nursing home and waiver programs. In 2015 the MAGI AND NON-MAGI application backlog was in excess of 100,000 cases with some dating back to 2013. This meant that clients had been waiting for two years to receive Medicaid! We took a long, hard look at our policies and procedures and made four major changes to improve our state of affairs.

The first change we made was to go from county based paper file case ownership, to electronic task based statewide casework. Prior to making the changes, each of our 46 counties operated on their own accord. Meaning, they were responsible for the clients that lived in their own county, only. If you were lucky enough to live in a larger county, you had the benefit of many workers with smaller caseloads to handle your case for quicker processing; however, if you lived in a smaller county, that caseload was much larger and it could take much longer to get to

your particular case, which meant you just had to wait your turn. This issue was magnified if a worker was absent since you would have to wait until they returned to work for them to evaluate your case and provide you with benefits. The clients were at the mercy of our caseworker's availability and our caseworkers built up backlogs if they took time off from work. So we transitioned to electronic casefiles, which enabled us to spread the casework out amongst the entire state. No longer did caseworkers have to manage a case from beginning to end and keep up the maintenance on that family's case for eternity, and no longer did clients have to wait for a particular worker to process their case, they now benefited from a whole statewide team to help them. Each case entered into the system is now automatically sorted into the proper queue based on the claim type and task required and a caseworker from anywhere in the state can claim and work the case regardless of its origin.

The second thing we did was look at our internal policies. We found many instances where we could simplify them, and we did. We started using reasonable compatibility. If a client claims to make a certain amount of income and we compare it to our income data bases and it differs by only a reasonable amount, we now accept that claimed income instead of pending the case and instructing the client to provide us proof. Another change we made was accepting attestations of income. For example: if a client was receiving money from a relative to help them pay their bills each month, we required them to provide a signed statement from that relative stating how much and how often they gave money. We realized that this income was never enough to put the client over the income limit for Medicaid, so we changed our policy to just accept the client's attestation on this contribution and not delay the case for this signed

statement. These changes allowed for first touch processing rather than having to pend a case awaiting further information that never had any bearing on the case decision.

The third thing we did was to create tools for our caseworkers. Medicaid policy requires many documents of evidence in order to make a determination. What we discovered was that each county had their own methods for collecting this evidence; some over verified and some under verified. So in order to assist the staff and to ensure that everyone was following the same procedures, we created verification matrices to ensure everyone was requesting the exact same pieces of information from the clients in order to make a determination. One of the biggest things we learned from moving to a task based system was that our caseworkers didn't always trust that the worker who touched the case before them followed the proper procedures; therefore, they were reworking the case from beginning to end to ensure it was correct. This added to our processing times. So, to combat this, we created a documentation log that allows caseworkers to notate what actions/evidence they found on the case before pending it for the next worker. Now the worker that claims it need only read that documentation template and pick up where the previous worker left off, thus reducing our processing time.

The last thing we instituted was a casework management tool that allows for real time data. We can now pull up any county in the state and know how many people are sitting in their lobby, how long they have been there, what services they are needing, and what the estimated time of service will be. That allows us to staff the queues according to the caseloads, in real time, to ensure our queues empty each day.

I am proud to say that with these changes the MAGI and NON-MAGI caseload now has zero backlog and you receive same day service when you apply for Medicaid services. However, these changes did not yield the same results for our LTC caseload. Our LTC caseload has ballooned over the last couple of years and created some negative favor with the Nursing Home Association of SC. My project was to see how we could improve our business processes for our Long Term Care (LTC) program to:

(1) Make it easier for our clients to apply for services

(2) Bring our processing times to within federal guidelines

(3) Help repair/strengthen our relationship with the nursing facilities in South Carolina.

Our LTC cases are some of our more difficult cases to process, and they are also our most costly. We need to, first and foremost, consider our clients' needs and how our backlog/delay affects them and/or their care. For these programs, we have to evaluate property values, property transfers, life insurance policies, investment properties/income that we don't have to deal with in our other categories. Combine this with the heartache of dealing with an elderly family member that now needs services/nursing home placement to meet their everyday care and it results in a lot of confusion for our clients.

This particular caseload results in a lot of questions from the clients, a lot of transferring paperwork back and forth between our agency and the client to get exactly what we need, and a lot of pending of cases waiting on information with a lot of different caseworkers handling the case. We often hear from our clients and our nursing facilities that they don't understand how to complete the application or what evidence they need to provide to us to make an

eligibility determination. To remedy this, we have now contracted with a new vendor to assist the facilities with placing applications for their patients. They will work directly with the facilities to answer any questions they may have regarding the completion of the application and detail exactly what information we need from the client in order to make that eligibility determination. Also a part of this contract, they are to create very detailed pamphlets for our LTC clients on what information they need to submit to us in order to process a Medicaid case. This pamphlet can be handed out at all hospitals, doctors' offices and nursing facilities around the state. We hope this will make the application process a much smoother experience for our LTC clients going forward.

Federal guidelines require us to make an eligibility determination on LTC cases within 90 days. Currently our average processing time is in excess of 250 days. (Appendix A) This is a result of many factors: not enough caseworkers to begin with; additional staff attrition due to promotions, retirements, resignations; and complicated policy guidelines that cause us to pend cases several times before being able to make a determination. Based on our average incoming number of applications, our studies show we need 86 workers to handle our current caseload and any new applications that come in. We had 62 LTC caseworkers when this study started. We have since hired 11 more staff, and have 9 additional individuals in the hiring process with HR. We have also studied our policies to determine where we could make some simplifications. Our biggest hold up seems to surround our 30 day wait. Currently our guidelines require a client to be in a facility or receiving waiver services for 30 days before we can approve the Medicaid case, which we then retroactively cover the 30 days of service. This 30-day wait

results in having to handle the case multiple times in order to approve it, which adds to our processing times. We have surveyed other states: Kansas, Texas and Alaska, and none of them have any such requirement; so we are now looking at revising our policy to exclude that requirement which should result in a quicker turn around and fewer times the case is handled.

When we restructured from case ownership to task based ownership, we brought our LTC workers into state office for work groups in order to guide them through this new process. What we discovered, is that they were far more productive when working as a group under the watchful eyes of managers than they were when we released them to go back to their individual offices with no onsite help. So we established a LTC processing center. These staff are immune to clients walking in off the street, phone calls, having to assist with other county duties, etc. They are just there to process cases 100% of the time. That, combined with them being in a group setting to seek help regarding questions involving difficult cases/issues that arise, will greatly increase production, thus reducing our overall processing times to bring them within federal guidelines. December was the first full month that the new processing center was fully operational. We saw increased production out of this staff and they were the only team statewide where every member met our utilization standards. (Appendix B)

We met with the Nursing Home Association to help identify problem areas that they felt were a problem for both our clients trying to apply for/obtain Medicaid and for the nursing facilities, themselves, as they try to assist their clientele through this process as well as trying to bill for services.

Some key problems identified were:

(1) DHHS may not have enough staff (addressed above)

(2) DHHS needs a separate policy and process director

(3) DHHS does not provide workers with Standards of Operating Procedures

(4) Training of staff needs to be ongoing

(5) The LTC application process lends itself to a high pend rate (addressed above)

(6) The application is not user friendly (addressed above)

(7) Information submitted seems to be getting 'lost' in our mailroom

As already mentioned above, we have already begun to address our staffing issue by hiring more LTC caseworkers. We have contracted with an outside vendor to aid the clients/nursing facilities through our application process and to create visual materials in order to make it more user friendly for our clients. We have also begun to look into our policies that cause high pend rates and are working to make some changes to reduce those.

To improve our staff training, we have created brand new curriculums that are more complete, while also allowing the staff to go back to their individual offices and practice what they learned before returning for additional training. In our previous model, the workers would come to a four to five day training and then be turned lose to process cases on their own. With this new model, we bring them in for a week to train on one topic and they go back and practice for a few days, then we bring them back for the next topic, etc. etc. While they are in their individual offices practicing what they learned, we have policy experts and team leaders that now sit with them to help guide them through the work. We are also creating ongoing training for the staff

to occur at least once a year to ensure everyone is up to date on policy and procedures as they are ever changing.

We performed an assessment of our mailroom to determine why things 'seem to get lost' and identified some key areas of change. Currently each document that is scanned in must be identified and sorted into the correct folder. For example: if it is income, it is typed as an income document and filed in the income folder; if it is a bank statement, it is typed as a resource and filed in the resource folder. We found that some workers scanned certain documents in as one thing, where another worker may scan it in as something else, thus creating an instance of 'not being able to find' a document. We are developing a very specific matrix to identify what types of documents should be scanned in as what until we can address the bigger problem: our scanning system needs to be studied and improved upon.

To help ease the problem of lost documents from our nursing facilities, we created a 'receipt' process. We created a checklist (Appendix C) that outlines the different types of information that may accompany a LTC application. When the mailroom receives the mail, they will complete this checklist with everything that was received and return it to the facility. This will alert the nursing facility that we received or did not receive the proper paperwork. We hope this is a giant step towards repairing that relationship as well as reducing the number of phone calls from the facilities asking about submitted paperwork. One thing we must consider with this new receipt process, is how much time this may add to our mailroom. We will have to

study it to see if we will need to hire additional staff to ensure we maintain our ability to scan in every piece of mail each and every day.

We will continue to perfect each of these new processes, look at hiring a processing director and creating a standard operating procedures manual for the staff in order to increase our chances for success.

In a more recent meeting with the Nursing Home Association, they informed us that they were unhappy with our statewide caseload model, and wanted us to go back to case ownership. They feel our production was much higher then and they liked having one person they could contact if they had questions regarding a specific case. This is also what we hear from our caseworkers when we survey them. Since these cases are more complex and detailed, they liked having a case from beginning to end because they feel like they build a rapport with the clients and can process the case more expediently, than starting and stopping in the midst of one. So in other efforts to repair our relationship with the Nursing Home Association, we began two other pilots today, February 5, 2018: case ownership and team ownership. We selected five caseworkers to take 150 cases each to maintain from start to finish. Anything needing to be done on these cases, the one caseworker must do. We also selected five caseworkers to work as a team, processing the same amount of cases (simulating our processing center). In this model, a case will originate in this unit and will be completed within this five person unit, just maybe not by the same caseworker. We will be comparing these two pilots for 90 days

against our current statewide processing model to determine which is the most productive and meets the needs of our agency as well as of the Nursing Home Association.

The goal of all of these changes is to reduce our processing times to bring them within the federal guidelines of 90 days, to make things easier for our clients/nursing facilities, and to better our relationship with the nursing homes around the state. To ensure we are on the right track and accomplishing these tasks, we will continue to meet with the Nursing Home Association and get their feedback on whether the 'loss of documents' decreases from our mailroom and whether our new vendor is able to assist them and the clients the way we anticipate when going through the application process to make things easier for them. Our biggest result will be in the processing times of our cases; because if we can improve on that, the other things will naturally take care of themselves as we will not build a backlog of applications waiting to be processed. As stated above, our current processing time is in excess of 250 days. To ensure we are progressing, we will chart our processing time each week to determine if we are indeed trending in the correct direction. If we determine we are not, we must re-evaluate and determine next steps.